Connecticut Department of Social Services
Making a Difference

Written Testimony of the Department of Social Services
Submitted to the Public Health Committee
February 17, 2017

S.B. No. 317 (PROPOSED) AN ACT CONCERNING COMMUNITY-BASED HEALTH CARE SERVICES

This bill would allow emergency medical services personnel to provide community-based health care services.

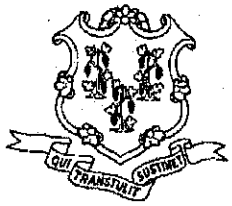
The Department appreciates the intent of this bill. In accordance with the provisions of section 359 of Public Act 15-5 of the June Special Session, the Department of Social Services and the Department of Public Health (DPH) recently issued a final report regarding the feasibility and advisability of providing community-based health care services through the use of paramedicine services. (Please find a copy of this report attached to this testimony.) The report addresses the following areas:

- context on health care needs and current care delivery interventions that DSS has implemented in Connecticut Medicaid that have led to a reduction in non-urgent use of 911 and emergency department services;
- review of community-based health care/paramedicine services covered by Medicaid in other states
    - analysis of existing best practice models
    - current scope of practice for emergency medical services personnel;
- an inventory and analysis of paramedicine options and the Departments' perspective on the feasibility of such options including, but not limited to:
    - expanded services- home visits, follow-up care, ancillary primary care
    - transport alternatives- transportation to a non-emergency department setting
    - "treat and non-transport" recognition
    - expanded access to patient records.

Currently, paramedics and other emergency medical services personnel are required to follow the scope of practice requirements outlined in chapter 384d of the Connecticut General Statutes (CGS), the regulations of Connecticut State Agencies and state standards and protocols. To expand the role of emergency medical services personnel, as this legislation proposes, a Scope of Practice Review would have to be requested through the established process with DPH. From a

Medicaid perspective, DSS would be unable to provide reimbursement to enrolled Medicaid providers until the expansion of services is reflected in an approved scope of practice.

In addition, as indicated in the joint report, because the potential cost exposure could out-weigh any possible savings, DSS is unable to endorse implementation of Medicaid reimbursement for "treat and non-transport." DSS will, however, continue to monitor alternatives to "treat and non-transport" to determine if a cost neutral proposal may be possible in the future.



Paramedicine Services

Public Act 15-5, June Special Session

January 13, 2017

Department of Social Services
Commissioner Roderick L. Bremby

Department of Public Health
Commissioner Raul Pino

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In accordance with the provisions of section 359 of Public Act 15-5 of the June Special Session, the Department of Social Services (DSS) and the Department of Public Health (DPH) hereby submit the final report regarding the feasibility and advisability of providing community-based health care services through the use of paramedicine services. In support of this inquiry, the Departments will address the following areas in this report:

- context on health care needs and current care delivery interventions that DSS has implemented in Connecticut Medicaid that have led to a reduction in non-urgent use of 911 and emergency department services;
- review of community-based health care/paramedicine services covered by Medicaid in other states
    - analysis of existing best practice models
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Context on Health Care Needs and Current Care Delivery Interventions for Medicaid Beneficiaries

Connecticut Medicaid care delivery interventions have already demonstrated progress in more effectively supporting the needs of members with complex health profiles, including, but not limited to, individuals who have historically used 911 and the emergency department on a frequent basis. Care delivery interventions include (1) the Person-Centered Medical Home (PCMH) initiative; (2) administrative services organization (ASO)-based intensive care management (ICM); and (3) health homes for individuals with behavioral health conditions. These interventions are summarized below. For more detailed information and data on high need, high cost Medicaid members and results of these interventions, please see this link for materials presented by DSS to the Medical Assistance Program Oversight Council (MAPOC).

Person-Centered Medical Home Initiative

DSS implemented its PCMH initiative on January 1, 2012, and further developed it over SFY 2016. The premise of a PCMH is that it enables primary care practitioners to bring a holistic, person-centered approach to supporting the needs of patients, while reducing barriers to

access (e.g., limited office hours) that have inhibited people from effectively using such care and utilizing 911 and emergency department services in non-urgent situations.

Through this effort, DSS is investing significant resources to help primary care practices obtain PCMH recognition from the National Committee for Quality Assurance. Practices on the formal path toward national recognition (known as the "glide path") receive technical assistance from DSS' medical ASO, Community Health Network of CT. Practices that have received recognition may be eligible for financial incentives including enhanced fee-for-service payments and retrospective payments for meeting benchmarks on identified quality measures. Practices on the glide path may also receive prorated enhanced fee-for-service payments based upon their progress on the glide path but are not eligible for quality payments at this time. Key features of practice transformation include embedding limited medical care coordination functions within primary care practices, capacity for non-face-to-face and after-hours support for patients, and use of interoperable electronic health records.

As of December 2016, a total of 110 practices were participating (affiliated with 433 sites and 1,497 providers). These practices were supporting 326,346 Medicaid members (43% of all served by the program).

Data Analytics and Administrative Services Organization-Based Intensive Care Management

By employing a single, fully integrated set of Medicaid claims data, which spans all coverage groups and covered services, Connecticut Medicaid takes full advantage of data analytic tools to risk stratify beneficiaries and to connect those who are at high risk, identify as high utilizers of 911 and emergency department services or who have complex health profiles with ICM support. Risk stratification is based on medical and pharmacy claims, member and provider records, and results from diagnostic laboratory and imaging studies. Factors used to determine risk include:

1) overall disease burden (through Adjusted Clinical Groups, which is a person-focused method of categorizing illnesses);
2) disease markers (through Expanded Diagnosis Clusters, which categorize cases with similar diseases or conditions);
3) special markers (Hospital Dominant Conditions and Frailty);
4) medication patterns;
5) utilization patterns; and
6) age and gender.

ICM is structured as a person-centered, goal-directed intervention that is individualized to each beneficiary's needs. Connecticut Medicaid's ICM interventions:

- integrate behavioral health and medical interventions and supports through co-location of clinical staff of the medical and behavioral health ASOs;
- augment the PCMH initiative;
- are directly embedded in the discharge processes of a number of Connecticut hospitals;
- sustain the reduction of emergency department (ED) usage, inpatient hospital admissions and readmission rates;
- reduce utilization in confined settings (psychiatric and inpatient detoxification days) among individuals with behavioral health conditions; and
- reduce use of the ED for dental care, and significantly increase utilization of preventative dental services by children.

Health Homes

DSS worked with the Department of Mental Health and Addiction Services to implement health homes for individuals who are diagnosed with an identified serious and persistent mental illness, have high expenditures, and are served by a local mental health authority.

Under this model, per-member per-month payments to mental health authorities permit them to incorporate advanced practice registered nurses (APRNs) within their existing models of behavioral health support. Health homes were launched in fall 2015.

Medicaid Coverage of Community-Based Health Care/Paramedicine Services In Other States

After a careful review of community-based health care implementation in different states, Minnesota was determined to be the leading example of state Medicaid coverage of paramedicine services.

In 2011, the Minnesota legislature enacted into law the new profession of Community Paramedic to meet the health care needs of recipients living in underserved communities.

Eligible Providers

Emergency Medical Technician – Community Paramedic (EMT-CP) who:

- Are certified by the Minnesota Emergency Medical Services Regulatory Board (EMSRB)
- Are employed by a Minnesota Health Care Program (Medicaid)-enrolled ambulance service

- Have a service scope agreement, based on the paramedic's skills, with the medical director of the ambulance service

To obtain a community paramedic certificate from the EMSRB, an applicant must have:

- A current paramedic certification of Emergency Medical Technician-Paramedic (EMT-P)
- Two years of full-time services as an EMT-P
- Graduated from an accredited course

Community paramedics assist in the care of recipients who:

- Receive hospital emergency department services three or more times in four consecutive months within a twelve month period;
- Are identified by their primary care provider as at risk of nursing home placement
- May require set up of services for discharge from a nursing home or hospital
- May require services to prevent readmission to a nursing home or hospital

Covered Services

Services must be part of the care plan ordered by the recipient's primary care provider (physician, APRN or physician's assistant). The primary care provider consults with the ambulance service's medical director to ensure there is no duplication of services.

Either the primary care provider or the medical director must coordinate the care plan with all local community health providers and the local public health agencies, including home health and waiver services, to avoid duplication of services to the recipient. Services the community paramedic may perform are:

- Health assessments
- Chronic disease monitoring and education
- Medication compliance
- Immunization and vaccinations
- Laboratory specimen collection
- Hospital discharge follow-up care
- Minor medical procedures approved by the ambulance medical director

Non-Covered Services

The following services are not covered:

- Travel time
- Mileage
- Facility fee

- Services related to hospital-acquired conditions or treatments.

Feasibility of Such Approach in Connecticut

DSS and DPH found it useful and informative to examine Minnesota's model. Having done so, however, DSS and DPH do not recommend that Connecticut take such a broad approach. Minnesota's key aim in its coverage of paramedicine was to address rural access issues. Connecticut is a small state that does not have comparable challenges, and also has many community-based providers of primary care and home health services.

Currently, paramedics and other emergency medical services personnel are required to follow the scope of practice requirements outlined in chapter 384d of the Connecticut General Statutes (CGS), the regulations of Connecticut State Agencies and state standards and protocols (see Department of Public Health website for individual licensure requirements). Emergency medical services personnel provide care within the "emergency medical service system" which is defined in section 19a-175, CGS, as "a system which provides for the arrangement of personnel, facilities and equipment for the efficient, effective and coordinated delivery of health care services under emergency conditions." This system is also referred to as the "911" or "pre-hospital" care system. Besides paramedics, additional lower levels of personnel are utilized including emergency medical technicians (EMTs) and emergency medical responders (EMRs). An "emergency medical service organization" is defined in section 19a-175, CGS, as "any organization whether public, private or voluntary that offers transportation or treatment services to patients primarily under emergency conditions."

Since this report anticipates scenarios in which emergency medical services personnel, in particular paramedics, could deliver an expanded array of services to the community, it is important to note how that term is applied in Connecticut. The term "paramedicine" is defined in section 20-206jj, CGS, as "the carrying out of (1) all phases of cardiopulmonary resuscitation and defibrillation, (2) the administration of drugs and intravenous solutions under written or oral authorization from a licensed physician, and (3) the administration of controlled substances, as defined in section 21a-240, in accordance with written protocols or standing orders of a licensed physician."

Inventory and Analysis of Paramedicine Options in Connecticut and Recommendations Moving Forward

Expanded Services

DSS and DPH solicited feedback from providers about the proposed expansion of the role of paramedics. Below please find their suggestions inventoried, and also find responses from the departments.

- *Home Health after hours*- Coordinated back-up services for nights, weekends and overnights when gaps are identified.
- *Paramedic surveillance*- Attend to a patient while awaiting home health resident nurse. Perform home environmental assessment. Perform patient assistance between primary care physician visits. Patient/caretaker education on ED alternatives.
- *Hospice 911*- Services include: education, patient/caretaker calming, "treat and non-transport" interventions, referral/connection to home health, availability when hospice on-call is busy or far away, and ability for appropriate transport when necessary.
- *Other non-911 services*- Services include: targeted patient services in-home, vaccine administration, screenings and chronic disease services/interventions, pre-admission services at home.

  Response: In order to move any of these initiatives forward, a Scope of Practice Review would have to be requested through the established process and completed by DPH.
  - Sections 19a-16d through 19a-16f, CGS, establishes a process for the submission and review of requests from health care professions seeking to revise or establish a scope of practice prior to consideration by the General Assembly. Under these statutes, DPH is mandated, within available appropriations, to (1) complete an assessment of any public health and safety risks that are associated with the request; (2) determine whether the request will enhance access to quality and affordable health care; and (3) determine whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training.
  - This statute also requires scope of practice requests to be submitted by August 15th of each year.

Transport Alternatives

- *Paramedic transportation to alternative settings*- Patients who call 911 and need urgent/timely care but do not need ED level of care.

Response:

- This proposal may be addressed through the development of a new protocol by the CT Emergency Medical Services Medical Advisory Committee (CEMSMAC), which is a standing committee under the CT Emergency Medical Services Advisory Board. The statutory mandate of CEMSMAC is to provide the Commissioner, the EMS Advisory Board and other ad hoc committees with advice and comment regarding the medical aspect of their projects. CEMSMAC's responsibility includes developing and helping to implement protocols for emergency medical services personnel.
- If the CEMSMAC, and subsequently the Commissioner of Public Health, approves an EMS protocol for transport to a setting other than a hospital, then hospital EMS medical directors would make the decision about which setting would be most appropriate for each patient. The sponsor hospital's EMS medical director is a licensed physician on the staff of the hospital who has specific training in emergency medicine and has been designated by the hospital to be medically responsible for the hospital's participation in the EMS system.
- There is no fiscal impact anticipated, so this option could be implemented once a protocol is approved.

- *Creation of a 911 alternative*- Local 10 digit number for residents to call when they need transports to non-ED settings.

Response:

- The Department of Emergency Services and Public Protection (DESPP) and the E911 Commission would need to approve the concept prior to any discussion, and neither DESPP nor DPH supports moving ahead with this option.
- A 911 alternative has the potential to be very confusing for the public. At this time, the E911 Commission's efforts and funding are otherwise focused on adding "text-to-911" capability statewide.

"Treat and Non-Transport" Recognition

- *Medicaid reimbursement for treat and non-transport*- Develop a rate to compensate paramedics for providing services without transport.

Response:

- DSS is unable to endorse implementation of Medicaid reimbursement for "treat and non-transport" at this time because of the potential for cost exposure that could out-weigh any possible savings.

- DSS will monitor "treat and non-transport" alternatives to determine if a cost-neutral proposal may be possible in the future.

- *Commercial rate for treat and non-transport-* Allow EMS to bill private pay and insurers for providing services without transport.

  Response:
  - Subsection (a)(9) of section 19a-177, CGS, allows the Commissioner of Public Health to establish rates for the conveyance and treatment of patients by licensed ambulance services and invalid coaches along with establishing emergency service rates for certified ambulance services and paramedicine intercept services under specific conditions. Any new established rates must be promulgated in regulations.
  - Existing insurance law, section 38a-498, CGS, requires insurance policies to include coverage for, at a minimum, transport when medically necessary to a hospital. As the minimum requirement is tied to transport, any additional required coverage would be considered a new mandate under the Affordable Care Act, and would require the state to defray the cost of providing the benefit for health care plans on the Exchange. The Insurance Department (CID) has reviewed this option but ultimately does not recommend moving forward due to the fiscal impact to the state.
  - If insurance coverage cannot be required for the provision of ambulance services outside of transport, any additional rate establishment would lead to costs for those services being directly borne by the consumer.

Expanded Access to Patient Records

- *Enhanced discharge notification-* Identify patients "at-risk" to local EMS for potential patient follow-up.

  Response:
  - In order for such an initiative to move forward, a Scope of Practice Review would have to be requested through the established process and completed by DPH.
  - Sections 19a-16d through 19a-16f, CGS, establish a process for the submission and review of requests from health care professions seeking to revise or establish a scope of practice prior to consideration by the General Assembly. Under these statutes, DPH is mandated, within available appropriations, to (1) complete an assessment of any public health and safety risks that are associated with the request; (2) determine whether the request will enhance access to quality and affordable health care; and (3) determine whether the request

enhances the ability of the profession to practice to the full extent of the profession's education and training.

- This statute also requires that scope of practice requests be submitted by August 15th of each year.

- *Bi-directional access/input to medical records*- Allow paramedics to access records for 911/alternative destination calls; allow documentation of patient services/conditions as a result of EMS intervention.

  Response:

  - Providers are encouraged to discuss this directly with sponsor hospitals. Neither DSS nor DPH have jurisdiction over this process. This initiative would be an administrative process change.

Conclusion

After a detailed review of the paramedicine options discussed in this report, DPH and DSS will proceed with the following action items:

- DPH will request that the CT Emergency Medical Services Medical Advisory Committee (CEMSMAC) review the feasibility of authorizing paramedic transportation to alternative settings.
- DSS will monitor "treat and non-transport" alternatives to determine if a cost-neutral proposal may be possible in the future.